

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 1900

## 1. PLACE OF DEATH:

County Balto. Howard  
 City or town E. Chridge Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Balto  
 City or town E. Chridge Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 19 Washington Blvd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Katherine  
bangani

## 3. (b) Social Security Number

no

4. Sex female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife Anthony bangani  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) Dec. 13 1870  
 8. AGE: Years 76 Months 11 Days 8 It less than one day  
 .....hrs. ....min.

9. Birthplace Italy  
 (Town, county, and state)  
 10. Usual occupation House wife  
 11. Industry or business at Home  
 12. Name Henry Parascia  
 13. Birthplace Italy  
 14. Maiden name Netina Lionareddi  
 15. Birthplace Italy

16. Informant Mary bangani  
 Address 19 Washington Blvd.  
 17. Removal Removal Date thereof Nov. 25 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Johns Cem.  
 Location Brooklyn New York  
 18. Funeral director Wm Cook Inc  
 Address 1217 St Paul St.

19. 11/24 46 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1946 at 11:45 P.M.  
 21. I CERTIFY that death occurred at the date above stated; that I attended deceased from Nov. 6 46 to Nov. 20 46  
 and that I last saw him alive on Nov. 20 46  
 Immediate cause of death Myocardial Infarct. -  
Ch. Hypertension  
 Due to Ch. Hypertension  
 Due to.....  
 Other conditions Serubity -  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE Frank Shipley M.D.  
Savage, Md. R D. or other  
 Address..... Date signed 11/24/46

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No.

1930

1. PLACE OF DEATH: *Howard*  
County.....  
City or town..... *Cooksville*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *one day*  
Hospital, institution, or street address where death occurred.....  
*Washington Road*  
How long in hospital or institution? *no*

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... *Maryland* County..... *Cooksville*  
City or town..... *Glenwood*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... *Washington Road*  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... *World War I*

3. (a) FULL NAME  
*Steve Columbus Dorsey*

3. (b) Social Security Number

4. Sex..... *Male* 5. Color or race..... *Colored* 6. (a) Single, married, widowed, or divorced..... *Single*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *1890 - Aug. 24* 6. (c) If alive, give age..... years

8. AGE: Years..... *56* Months..... *2* Days..... *13* If less than one day..... hrs. .... min.

9. Birthplace..... *Cooksville, Howard Co. Maryland*  
(Town, county, and state)

10. Usual occupation..... *Hardy Man*

11. Industry or business..... *Saloon*

FATHER 12. Name..... *Joseph Dorsey*  
13. Birthplace..... *Cooksville, Maryland*

MOTHER 14. Maiden name..... *Maria Prettyman*  
15. Birthplace..... *Dorsey, Maryland*

16. Informant..... *Eugene Dorsey (brother)*  
Address..... *Brookville, Maryland*

17. *Buried* Date thereof..... *Nov 9 1946*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *Buried*  
Location..... *Cooksville, Maryland*

18. Funeral director..... *Box W Barber*  
Address..... *Dorseyville, Md*

19. *11/8/46* *E. Paul Quinn*  
(Date reg'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *November 6 1946* at *11:15 P.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*November 6 1946* to *November 6 1946*  
and that I last saw him alive on *at no time* 19.....

Immediate cause of death..... *Coronary Embolism* DURATION..... *15 min*

Due to.....  
Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
Means of Injury..... Injured at work?

23. SIGNATURE..... *Alpha N Herbert M.D.*  
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other  
Address..... Date signed.....

RECEIVED  
NOV 14 1945  
OFFICE OF THE  
ATTORNEY GENERAL

2-35-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 150

## 1. PLACE OF DEATH:

- (a) Baltimore City, Maryland Howard Co  
 (b) Street address R.F.D. - Ellicott City, Md.  
 (c) Hospital or institution:

- (d) Length of stay in hospital or inst. (yrs., mos., or days)  
 (e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Howard  
 (c) City or town Ellicott City  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. R.F.D. Ellicott City, Md.  
 (If rural give location)  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country

## 3 (a) FULL NAME

Norothy Grove

## 3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Married

- 6 (b) Name of husband or wife Charles Richard Grove  
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)
- May 11, 1923

8. AGE: Years 23 Months 5 Days 5 If less than one day  
 hr. min.

9. Birthplace Baltimore, Md.  
 (Town, county, and state)

10. Usual Occupation
- Housewife

11. Industry or business

- FATHER 12. Name Jacob Oberholtzer  
 13. Birthplace Pa.

- MOTHER 14. Maiden Name Rachel Warram  
 15. Birthplace Bethesda, Md.

- 16 (a) Informant Dr. Leo Burkhart  
 (b) Address Ellicott City, Md.

- 17 (a) Burial (b) Date thereof 11 / 20 / 46  
 (Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory

Location

- 18 (a) Funeral director Easton Lord  
 (b) Address Ellicott City, Md.

- 19 (a) 11-18-86 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH
- Nov 16
- 19
- 46
- , at
- 1:25
- M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

## IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary
- ☐
- or contributing
- ☐
- cause of death, fill in the following:

- (a) Date of injury at M.  
 (b) Where did injury occur?  
 (c) Did injury occur at home, on farm, industrial place, in public place? While at work?  
 (d) Means of injury

23. Signature Howard J. ... M.D.  
 Date signed 11-18-46 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 11113 1910

## 1. PLACE OF DEATH:

County HOWARDCity or town RURAL - ELLICOTT CITY  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? SIX DAYS

Hospital, institution, or street address where death occurred:

PINEL CLINICHow long in hospital or institution? SIX DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTO CITYCity or town BALTIMORE  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3831 LEWIN AVE  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

LEISER LIEBERMAN

## 3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED

6.(b) Name of husband or wife

ANNIE

7. Birth date of

deceased (mo., day, yr.)

1856

6.(c) If alive, give age years

1 MONTH AND DAY  
UNKNOWN

8. AGE:

Years

Months

Days

If less than one day

90

hrs. min.

9. Birthplace

RUSSIA

(Town, county, and state)

10. Usual occupation

TAILOR

11. Industry or business

MOTHER FATHER

12. Name

Not Known

13. Birthplace

Russia

14. Maiden name

Not Known

15. Birthplace

Russia

16. Informant

MR ELLIS LIEBERMAN

Address

3831 LEWIN AVE BALTO MD

17.

(Burial, cremation, or removal. Which?)

Date thereof

11-19-46  
(month) (day) (year)

Cemetery or crematory

Resdale

Location

Phil Del + Hamilton Ave

18. Funeral director

Address

11439 E. Balto St.

19.

Nov 19 19 46  
(Date rec'd by registrar)R. St. Hedrick  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 18<sup>th</sup> 19 46, at 3<sup>30</sup> P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOVEMBER 13<sup>th</sup> 19 46, to NOVEMBER 18<sup>th</sup> 19 46.and that I last saw him alive on NOVEMBER 18<sup>th</sup> 19 46.

Immediate cause of death

CORONARY OCCLUSION

DURATION

2 HOURS

Due to

GENERALIZED ARTERIO-  
SCLEROSIS

Due to

Other conditions SENILE PSYCHOSIS6 MONTHS

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Holmut Rager, M.D.

M. D. or other

Address

Ellicott City, Md.

Date signed

11/18/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1940

1. PLACE OF DEATH:  
County... Howard  
City or town... Clarksville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State... Maryland County... Howard  
City or town... Clarksville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(d) If veteran, name war

3. (a) FULL NAME  
Charles R. Purdum

3. (b) Social Security Number  
- - - - -

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Emma J. Purdum  
6.(c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) January 20, 1866  
8. AGE: Years 80 Months 9 Days 24 It less than one day  
hrs. min.

9. Birthplace Howard County, Maryland  
(Town, county, and state)  
10. Usual occupation retired farmer  
11. Industry or business farm

FATHER 12. Name Charles T. Purdum  
13. Birthplace Maryland  
MOTHER 14. Maiden name Harriett Hobbs  
15. Birthplace Maryland

16. Informant Mrs. J.W. Parlett  
Address Clarksville, Md.

17. Burial Date thereof Nov. 16, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Mt. Zion  
Location Highland, Md.

18. Funeral director F.C. Higginbotham  
Address Ellicott City, Md.

19. Nov. 18 1946  
(Date rec'd by registrar) Registrar Marie G. Whitaker

### MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1946 at 5:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 1946 to November 13 1946  
and that I last saw him alive on November 13 1946

Immediate cause of death Acute cardiac failure DURATION 24 hrs.

Due to Chronic myocarditis 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results small, atrophic heart

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles S. Whitaker, M.D.  
M. D. or other

Address Clarksville, Md. Date signed 11/15/46

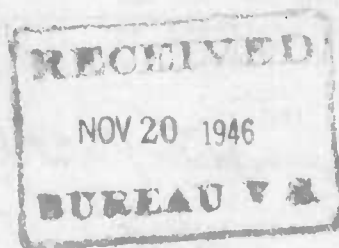
MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

## CERTIFICATE OF DEATH

11115  
Reg. Dist. No. 1910

### 1. PLACE OF DEATH:

County HOWARD  
City or town ELLIOTT CITY  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MARYLAND County HOWARD  
City or town ELLIOTT CITY  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. FREDERICK ROAD  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

DAVID THOMAS TITTS WORTH

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced MARRIED  
6.(b) Name of husband or wife EDITH  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) JULY 13 1918  
8. AGE: Years 68 Months 4 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### MEDICAL CERTIFICATION

2D. DATE OF DEATH NOVEMBER 25 1946 at 6:45 P. M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 19\_\_\_\_ to Nov 25 1946 19\_\_\_\_  
and that I last saw him alive on Nov 23 1946 19\_\_\_\_  
Immediate cause of death \_\_\_\_\_  
DURATION  
Due to Malignant tumor - left lung 1 yr  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace MARYLAND  
(Town, county, and state)  
1D. Usual occupation PLUMBING CONTRACTOR  
11. Industry or business  
12. Name ELSHA TITTS WORTH  
13. Birthplace TENN  
14. Maiden name CATHERINE MCKENZIE  
15. Birthplace Md.

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

16. Informant SEVERN TITTS WORTH  
Address ELLIOTT CITY MD.  
17. BURIAL Date thereof 11-28-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory ST JOHNS  
Location ELLIOTT CITY MD.  
18. Funeral director F.C. HIGGINBOTHAM  
Address ELLIOTT CITY MD.  
19. Nov. 28 1946 John B. Longhman  
(Date rec'd by registrar) (Signature) Registrar

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE Robert B. Taylor MD M. D. or other  
Address 104 W. Madison St Date signed 11-27-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
NOV 30 1946  
BUREAU V B

RECEIVED  
NOV 30 1946  
BUREAU V B

1-35-